Your HMO & You

What You Need to Know About Health Maintenance Organizations

A New Hampshire consumer's guide
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Insurance Department

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HMOs approach your health care in a new way. That's why you should, too.

If you join a *health maintenance organization*, or HMO, you'll be starting a new kind of relationship with a health care insurer. It will work best if you play an active role.

For a fixed amount of money, usually less than traditional insurance plans charge, the HMO agrees to pay for or provide the care that you need. But there are trade offs. In exchange for lower costs, the HMO will limit your selection of doctors, and it will also place some limits on services, medications and types of treatment. You will have lower out-of-pocket costs, and little paperwork. The HMO will commit to providing responsible, high-quality care.

By offering these trade offs, HMOs are making health care coverage affordable for millions of people, including thousands of New Hampshirites. But only you can decide whether a particular HMO's plan is right for you.

You need to ask questions, and to look carefully at how the HMO works. If you do join one, you'll get the most out of your membership if you continue to make sure you know how your care is managed, and how its quality is protected. If you and your HMO disagree, you should know what to do then.

This booklet was prepared by the State of New Hampshire Insurance Department -- the office that licenses insurers to operate in the State and protects the consumers of health care. If you're thinking about joining an HMO, reading this booklet is a good place to start.

If you are thinking about joining an HMO, you should know:

- **What an HMO is.**

A health maintenance organization contracts with an employer or the government to provide a package of health care services to a specific group of people for a set monthly price. This payment arrangement differs from traditional *fee-for-service* systems, in which health insurance companies agree to pay physicians and other providers -- such as hospitals, physical therapists, mental-health professionals or others -- for each individual service. **HMOs can deliver more efficient, more affordable, better-coordinated care. But in return, your choices about the care you receive may be limited.**

If you select an HMO, you need to know how to get the medically necessary care you need. This booklet tells you what to consider -- and what **questions you should ask** -- before joining. If you do join, it tells you how to work with an HMO. It describes **your rights as a consumer** under New Hampshire law -- and it explains **what to do and whom to call** if you have questions or concerns about your health plan or the quality of the services you are getting.

- **How HMOs work.**

When you select an HMO you trade some of your freedom to go directly to any doctor or hospital of your choice, in exchange for lower health insurance premiums, deductibles and/or co-payments. You must choose a primary care physician from doctors or other health care providers on the HMO's list (or network). Your current doctor may be on the HMO's list. In return, the HMO -- which may also be called a *managed care organization* -- coordinates your health care services. This may simply mean you must see your primary care doctor to get a referral to another provider. Or it may mean the HMO actively plans and oversees an array of health services for you. The HMO may also offer additional benefits, such as wellness programs. The plan oversees the quality of all services you get.

Your primary care physician is responsible for managing your care, either by providing or supervising it, or by coordinating your care with another professional. Under most HMOs' plans, your primary care physician also handles any specialist referrals you may need. (This is often called the *gatekeeper* approach.) In a few cases, such as obstetrics-gynecology or mental health services, your plan may allow you to go directly to the provider of your choice for one or more visits, so long as he/she is part of the plan's network. When this happens, your primary care physician will usually be notified, and information about the specialty service you received will be entered in your health record. **Check your HMO's requirements before you make an appointment with any specialist** or specialty service.

If you choose to see a physician or other provider who is not in the plan's network, you may be required to pay all or a portion of the cost. The HMO is required by New Hampshire law to

describe such coverage limitations to you in writing.

Except when you choose to see a provider who is not in the network, **the HMO is responsible for the cost and quality of the care you receive.**

Some health plans have a ***"Point of Service"*** **option.** Point of Service lets you go to a provider who is not in the plan network; in exchange, you pay higher co-payments and deductibles.

- **Why quality oversight matters.**

Quality oversight is especially important under managed care because **the HMO receives a fixed amount of money to provide all your health care services.** HMOs developed, after all, in response to the rising costs of fee-for-service care. And while fee-for-service payment systems can encourage providers to provide too many services, **the fixed payment system may create incentives to limit needed care,** particularly if expensive services are involved.

To offset this, well-organized HMOs monitor the amount and kind of care you receive to ensure that it meets quality standards. So **when you are choosing an HMO, it is very important to check its quality assurance features.** You may ask, for example, to see the results of the HMO's patient satisfaction surveys. Ask about their complaints history; or to review its regular evaluations of plan services. You may also wish to note the overall consumer friendliness of the organization.

Some questions you should ask in deciding whether to join an HMO:

The person you will speak with about joining an HMO will usually be one of its *member service representatives.* Here are some questions to ask him or her.

1. First of all, ask to see the member handbook, a list of service providers, and any other brochures and publications that describe the HMO's services. **Make sure you receive a list of covered benefits and exclusions.** If the HMO offers a choice of benefit packages, compare benefits, premiums and your out-of-pocket costs.

The material you receive from the HMO should clearly state:

- The names of the primary care physicians, hospitals and specialty providers currently accepting patients in the HMO network, and where their services are provided.

- What services are covered benefits, and which services are excluded (for example, are dental and home care services covered benefits?).

- Which services require prior authorization.

- Which services require referral by your primary care physician.

- When and how often you may change doctors, along with the process for doing that.

- How to get emergency and after-hours care, and whether you must first contact your primary care physician before receiving it.

- How to handle authorization and payment for medical care if you need it when your travel.

- Costs for which you are responsible.

- Whom you can call with a question, concern or complaint.

- How to file a complaint if you believe you have been denied necessary care, and how the appeal process will work.

2. Ask whether you will have to change physicians. If your doctor is not on the HMO's lists, you may not be able to continue as his/her patient. Some HMOs permit you to stay with your doctor for a limited time. If you must (or wish to) select another physician, ask which doctors on the roster are taking new patients, and how long it will take to obtain a first appointment.

3. Ask what the plan's rules are about switching doctors. Some plans permit this at any time; others allow you to switch only once a year.

4. If you are receiving a course of treatment from a physician or a counselor who is not on your HMO's list, ask how you may continue with your current provider to complete the treatment. Be sure to ask whether the plan will pay for the remaining treatment.

5. If you are likely to use specialty health services, ask to see the list of specialists in your area. Ask which ones are taking new patients.

6. If you have a chronic health problem and will require the ongoing services of one or more specialists, ask how the plan coordinates the care you will need. Will there be a standing referral, or must you obtain a referral from your primary physician for each specialist appointment or test? If you must get a referral each time, **find out how long it takes** to get one, and how long you must wait between appointments. Ask how many specialist appointments are covered per year under plan benefits.

7. Ask how the HMO determines if a treatment is experimental. Ask how decisions are made to provide or deny payment for such services. If you have a serious illness or are at risk of contracting one, this may be important to you.

8. Ask what the plan's rules are if your primary care physician refuses to make a referral that you believe you need. Ask what options you will have.

9. Ask if the plan has a list of the medications it covers. If you are on maintenance medications, ask whether the plan covers the drugs you take. If the plan reimburses you for covered medications and you wish to save money by buying in volume, ask if the plan limits the amount of the medication that you can buy at one time.

10. Ask what the plan's rules are about emergency room use. Most

HMOs require that you try to call your primary care physician as soon as possible if you expect the plan to pay. Ask who pays for the service if you do not have prior plan approval.

11. If you travel often out of your home area, ask how emergency health services will be coordinated and payment arranged should you need care while you're away.

12. Ask to see the plan's consumer satisfaction and other quality performance ratings, such as the waiting time for appointments. Check to see which areas score low and which score high. Consider how important the high-and low-scoring areas of care are for you.

13. Ask whether the HMO gives financial incentives to any health care provider to reduce or limit care. If so, ask for an explanation of how this works.

14. Ask whether the HMO is accredited by a national quality-assurance organization. One of these is the National Committee for Quality Assurance (202-955-3500 or http://www.ncqa.org). Others are the Joint Commission of Accreditation of Health Care Organizations (630-792-5000 or http://www.jcaho.org); and the American Accreditation on HealthCare Commission, Inc. (202-296-0120 or fax 202-296-0690).

15. Ask how often the HMO updates its practice guidelines to reflect new treatment knowledge. This may be important to you if you are at risk for certain health conditions. **If you have a medical condition, ask to see the practice guidelines that apply to you.**

16. Ask how appeals are handled, how many appeals the HMO received during the past year, and what they were about. Ask about the processes the plan uses to resolve member problems and complaints. **Ask to see the plan's complaints and appeals report** for the past year.

Also:

If your employer is considering switching to an HMO, ask your personnel officer to discuss your particular questions and concerns with the HMO sales representative. You may wish to ask the personnel officer to check with other companies to learn about their experience with the HMO in terms of employee satisfaction, costs and access to necessary care.

It's important for you to let your employer know your likes and dislikes at any time, so s/he can decide whether or not to change plans.

If you decide to join...

Here's how to work with your HMO to get your health needs met:

- **Learn how your HMO works.** Read the member's handbook, and other materials that you're supplied. If you don't understand something, ask. This can save you and your health plan staff time and frustration.

- **At the first appointment with your primary care physician, ask about how your care will be managed.** This is especially important if you have a chronic illness that requires ongoing appointments with specialty providers. Ask whether you will have standing referrals, or if you will need to have your primary care physician (your PCP) approve each visit to your specialist. Ask how long approval will take.

Ask how your care will be coordinated. For example, will your primary care physician call to request specialty test reports, or will you be responsible for seeing that information like this is sent to the PCP? It is important to ask these questions even if you already got this information during the enrollment process.

- **Schedule regular checkups, and keep your appointments.** If you must cancel, call 24 hours in advance if possible. Your HMO may require four to six weeks to schedule a routine examination.

- **If you are seeking a specialty provider for the first time,** check with your primary care physician to find out which providers are on the HMO's list. Most specialty referrals require prior physician approval to make an appointment. A few (such as OB-GYN) may be contacted directly, but you must have plan or PCP authorization for continued care. *Check plan rules before making an appointment.*

- **Use the emergency room only for medical emergencies.** Make sure you understand your HMO's rules for emergency room use.

- **Use the plan's prevention and wellness programs.** These programs are designed to help you live a healthy lifestyle. The HMO has an interest in keeping you healthy -- and so, of course, do you.

- **Become an active partner in your health care.** Ask your health care professionals questions about your condition and the prescribed treatment.

  By asking questions and following plan procedures, you should be able to get satisfactory, cost-effective, good quality care. **Occasionally, however, you may feel you need more or different care than you are getting.** If this happens, you should discuss your concerns with your doctor and/or other representatives of your health plan. And you should know about the legal protections you have.

These are your rights under New Hampshire law:

The New Hampshire Insurance Department is responsible for regulating licensed HMOs to make sure they meet legal standards for solvency, quality and consumer protection. As part of this responsibility, the Department administers very specific consumer protection provisions of the law.

- **It is illegal for managed care organizations to include "gag clauses" in their contracts with**

health care providers. "Gag clauses" prevent doctors or other health care professionals from telling HMO members about services or treatments that the plan's rules restrict your ability to get. Your physician or other provider is free to tell you what treatments exist for your condition -- and which ones your health plan will and will not cover.

- **You have a right to know if some services are not covered.** The HMO must describe its limitations on treatment or referrals.

- **You have the right to know if the HMO requires prior approval for referrals or specialty services.** The plan must tell you the procedures it requires to obtain approval.

- **You have the right to continue to receive mental health benefits from the same provider for one year** if your employer switches from one HMO to another and your provider is not in the new HMO's network.†

- **You have the right to receive a reasonable and understandable explanation** of any denial of medical services made on the basis of their not being medically necessary.

- **You have the right to obtain assistance from your HMO if you decide to file a grievance** about services which the HMO has determined are inappropriate or not medically necessary.†

If you believe you are being denied medically necessary care:

1. First, talk with your doctor. Most questions and concerns can be resolved by talking directly with your physician or other health care provider. *Get the support of your primary care physician whenever possible.* Your doctor should work to get you the medically necessary care you need. Ask him/her why the treatment has been denied and who made the decision.

2. If your doctor is not responsive, ask for a second opinion from another of the HMO's physicians. If your doctor is reluctant to refer you for a second opinion, discuss the matter with an HMO member service representative.

3. If this does not remedy the situation, ask to talk with the HMO's medical director. The medical director oversees all medical services, and can tell you what the plan will and will not do in most situations.

If you and your HMO continue to disagree:

4. You may want to seek a medical consultation with a physician who is not paid by the HMO. This physician may be willing to write a letter on your behalf to your doctor and the medical director -- or the president -- of the HMO. If you decide on this action, check to see if the HMO's rules include paying for outside consultations. The

plan may not be willing to do this. **To protect yourself, insist that any questions or complaints about your treatment be made part of your medical records.**

5. You can always contact the New Hampshire Insurance Department for help. The Department's staff are available to assist you during business hours -- Monday through Friday 8:00 a.m. until 4:30 p.m. *Call 603-271-2261 and ask for the consumer advisor. Or call the toll-free number: 1-800-852-3416.*

6. Consider telling your employer about the situation. Your employer or your company's benefits coordinator may be able to get the HMO to provide coverage. *Be aware, however, that you will lose privacy if you choose to involve your employer.*

7. If you still believe you need medical services that the HMO will not provide, ask the member service representative to put the plan's decision and the reasons for it in writing.

8. Ask about the HMO's appeals process. Information on this process must be clearly stated in writing and made available to all plan members.

9. Appeal the decision. If you decide to file an appeal, follow the steps outlined in the HMO's appeals process. The plan will tell you how long this will take and who will be involved in ruling on the appeal. The first step is to submit a written request for the service or treatment. Your case must be reviewed promptly. (Medicaid and Medicare recipients are entitled by law to have appeals reviewed by an outside panel. If you have questions regarding Medicare A you can call 695-7000; Medicare B, call 1-800-447-1142; Medicare Managed Care, call the Health Care Financing Administration at 1-800-638-6833; for Medicaid call the New Hampshire Department of Health and Human Services, 271-4344)

10. If you believe that the HMO has not followed its own grievance procedures in your appeal, you may have the HMO appeal reviewed by the New Hampshire Insurance Department.

Any time you need more help:

Contact the Consumer Advisor at the New Hampshire Insurance Department or call toll-free 1-800-852-3416. A staff member will talk with you about your situation, and will request that you submit a letter and any related documents describing your problem.

After you submit this material to the Department, our staff will review your situation and determine whether the HMO has violated the law. Department staff may call the HMO to encourage a quick resolution of the dispute, even in cases where there is not a clear violation.

If the plan has violated the terms of your insurance contract, violated quality assurance rules or failed to observe your appeal rights, it may be subject to legal sanctions or penalties.

Department staff will track your situation until it is resolved.

† Provisions of RSA Ch. 420-J, effective January 1, 1998.

For immediate help, call the Department's toll-free number: 1-800-852-3416

or write

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